



# CERTIFICATION - PLAN OF CARE FOR INPATIENT PSYCHIATRIC HOSPITAL SERVICES / DETERMINATION OF MEDICAID ELIGIBILITY

State Form 44697 (R3 / 11-00) OMPP 1261A

## PRIOR AUTHORIZATION NUMBER

Medicare

☐ Yes ☐ No

## COMPLETED BY PROVIDER

Medicaid number

## COMPLETED BY HOSPITAL PERSONNEL

Provider hospital (name, address, city, state and ZIP code)

## PATIENT IDENTIFICATION

Name (first, middle, last)

Sex

Race

Age

Date of birth (month, day, year)

Marital status

Number of children

Date of admission (month, day, year)

Time of admission

☐ AM ☐ PM

Admitted from:

☐ Other (designate)

☐ Own home

☐ Parents' home

## AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize release of information when necessary for determination of my eligibility for Medicaid.

Signature of patient, responsible relative or guardian

Date signed (month, day, year)

## I. PSYCHIATRIC AND MEDICAL EVALUATION

Height

Weight

Blood pressure

Systolic:

Diastolic:

Significant laboratory data

Blood work:

Radiological:

Psychological testing:

Pertinent psychiatric history as related to this illness (include medical history)

Estimated length of inpatient treatment (be as specific as possible)

**PSYCHIATRIC AND MEDICAL EVALUATION** *(continued from previous page)*

Significant findings upon current mental examination

Significant findings upon current physical examination

Primary psychiatric diagnoses

Secondary psychiatric diagnoses

**Functional Capacity**

Can patient take own medication? ☐ Yes ☐ No

Is patient capable of handling own affairs? ☐ Yes ☐ No

Mental capacity

Physical capacity

**II. PLAN OF PSYCHIATRIC TREATMENT**

State treatment objectives, long and short range *(include estimated timetable)*

**PLAN OF PSYCHIATRIC TREATMENT** *(continued from previous page)*Treatment modalities for attainment of objectives or relating to specific problems *(check appropriate items)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Behavior modification    | <input type="checkbox"/> Marital counseling  | <input type="checkbox"/> Occupational therapy      |
| <input type="checkbox"/> E.C.T.                   | <input type="checkbox"/> Medication          | <input type="checkbox"/> Recreation therapy        |
| <input type="checkbox"/> Family therapy           | <input type="checkbox"/> Milieu therapy      | <input type="checkbox"/> Supportive therapy        |
| <input type="checkbox"/> Group psychotherapy      | <input type="checkbox"/> Music therapy       | <input type="checkbox"/> Symptom relief            |
| <input type="checkbox"/> Individual psychotherapy | <input type="checkbox"/> Nutritional therapy | <input type="checkbox"/> Vocational rehabilitation |
| <input type="checkbox"/> Other                    |  |  |

Describe modalities

Discharge plans - coordination of services

State names of relatives with whom the Treatment Plan was discussed and their relationship to the patient

**Designate the persons responsible for formulating the Treatment Plan:**

NAME	PROFESSION	NAME	PROFESSION

**III. CERTIFICATION**

A. UNDER AGE 21: Interdisciplinary Team Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment. These treatment services will improve the patient's condition so that inpatient services will no longer be required. Available alternate community resources do not meet the patient's needs. The Plan of Treatment identified above is verified as existing or implemented on this date.

Signature of Physician Team Member

Date signed (month, day, year)

B. AGE 22 TO 65: Interdisciplinary Team Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment. These treatment services will improve the patient's condition so that inpatient services will no longer be required. Available alternate community resources do not meet the patient's needs. The Plan of Treatment identified above is verified as existing or implemented on this date.

Signature of Physician Team Member

Date signed (month, day, year)

C. AGE 65 OR OVER: Physician's Certification: Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment which is necessary to maintain the patient or restore him/her to the greatest possible degree of health or individual functioning. The Plan of Treatment identified above is verified as existing or implemented on this date.

Signature of Attending or Staff Physician

Date signed (month, day, year)

**IV. MEDICAID AGENCY DECISION**

The Office of Medicaid Policy and Planning Review Physician has reviewed the content of this patient referral and has taken the following action.

☐ APPROVAL☐ DISAPPROVAL

Comments

Signature of Review Physician

Date signed (month, day, year)